



'If they didn't support me, I most likely wouldn't be here': Transgender young people and their parents negotiating medical treatment in Australia

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ABSTRACT

Background: It is increasingly recognized that transgender young people require affirming medical care, however the provision of such care may be mitigated by the availability of services and the views of parents.

Aims: This study aimed to explore the views of Australian transgender young people (aged 11–17) and their parents with regards to medical treatment.

Methods: Ten qualitative interviews were conducted with parent-child dyads in two Australian states. Thematic analysis was undertaken on responses to interview questions related to family relationships, views about medical treatment (specifically hormone blockers and hormones), and the relationship between medical treatment and sense of self.

Results: Themes developed focused on the importance of strong supportive parent-child relationships, the meaning of and access to hormone blockers, and the meaning of and access to hormones.

Discussion: The paper concludes by discussing the implications of the findings for clinical services, particularly in relation to supporting parents to be affirming of a transgender child, the need to prepare transgender young people and their parents for the passage of time in regards to medical treatment, and the need to focus on expectations in regards to sense of self in relation to medical treatment.

KEYWORDS

transgender; medical treatment; parent-child relationships; clinical care; qualitative study; youth

Introduction

Over the past decade it has been increasingly recognized that transgender young people need affirming medical care (Ehrensaft, 2011; Keo-Meier & Ehrensaft, 2018; Malpas, 2011). Such care treats as valid transgender young people's genders, is guided by young people's expressed needs, and aims to facilitate timely access to services (Riggs, 2019). In Australia, where the research reported in this paper was undertaken, affirming approaches have been increasingly adopted, with practice guidelines released by the *Royal Children's Hospital* in Melbourne (Telfer, Tollit, Pace, & Pang, 2018) being praised internationally as representing "respectful gender-affirming care" (The Lancet, 2018, p. 2576).

Such affirming care, however, occurs in a context of healthcare systems that are often stretched to their limits. This has implications for how

treatment is provided, particularly in terms of wait times for initial appointments (Gridley et al., 2016; Sansfaçon et al., 2019). Further, and particularly for young transgender children, access to services is often only possible with the support of parents. The views of parents, then, are not simply central to treatment decisions, but are formative of whether or not treatment is even sought (Gridley et al., 2016; Newhook, Benson, Bridge, Crowther & Sinnott, 2018).

In Australia these points about healthcare systems and parental consent are now even more salient, given recent changes to the regulation of treatment. Historically, it was necessary for parents to petition the Family Law Court in order to authorize treatment for children. In 2013 and 2017, decisions were handed down that made it no longer a requirement to petition the Court, instead finding that treating clinicians can make

decisions about medical treatment (Telfer, Kelly, et al., 2018). As noted above, however, despite these legal determinations making it somewhat easier for transgender young people to access services, issues of the availability of services and support from parents remain pressing. This is particularly true given that, despite the legislative change noted above, treatment for transgender young people in Australia still requires parental consent. Whilst a very small number of young people have been assessed as competent by the Court and granted leave to authorize their own treatment, it is primarily the case that absent of parental support, accessing medical treatment is difficult for transgender young people in Australia.

The research reported in this paper sought to explore how a sample of transgender young people and their parents living in Australia experienced clinical services, and how this was shaped by institutional factors and parental views. Specifically, the research reported in this paper focused on two Australian states – Victoria and South Australia – in which gender services for young people exist. In Victoria, the *Royal Children's Hospital* provides a dedicated gender clinic and is the most comprehensive in Australia. In South Australia a gender clinic exists at the *Women's and Children's Hospital* that, whilst not formally badged as such, offers services specific to transgender young people. Whilst transgender young people and their families can access services outside these two gender clinics (i.e., for counseling and assessment, if required), access to medical treatment is largely restricted to the hospital setting in Australia. Further, and whilst the pilot study reported in this paper was limited to these two states, it should be noted that gender services for young people also exist in New South Wales, Queensland, and Western Australia.

Method

The project

The research reported in this paper represents the Australian iteration of a Canadian study led by the third author (Sansfaçon et al., 2019), with

another iteration currently being undertaken in Switzerland. The study seeks to explore the experiences of transgender young people and their families who access care during pre-pubertal, pubertal and post-pubertal stages of development, to understand the motivations and pathways that lead them and their families to seek care, the issues affecting them, and the strategies they use to express and/or address dysphoria with the help of gender clinics and in larger social contexts. To date, studies conducted in each of the countries have focused on issues, challenges and needs specific to the country, as is the case for the present paper. The larger goal in collecting data in different countries, however, is to engage in cross-country comparative analyses, so as to identify common issues, challenges, and needs, as well as identifying strengths in relation to clinical care for transgender young people across countries.

Ethics

Ethics approval for the Australian iteration of the international project reported in the present paper was granted by the Flinders University Social and Behavioral Research Ethics Committee and the research ethics board of the University of Montreal. All procedures were undertaken in accordance with the ethical standards of the institutional research committees and with the 1964 Helsinki declaration and its later amendments.

Information regarding the study was distributed by a group for parents with transgender and gender diverse children, asking parents to contact the research team if they and their child were interested in participating. Upon contacting the research team, potential parent participants were provided with two information sheets: one for themselves, and one for their child. The latter was written in a way so as to be intelligible to young people. Both information sheets outlined the focus of the project, what was being requested of participants, and contacts should they need support following participation. Having read the applicable information sheet, both parent and child participants signed the consent form, and parents completed a demographic sheet before scheduling an interview.

Study design

Inclusion criteria were (1) being a parent/transgender child dyad willing to be interviewed together (young people aged between 11 and 17); (2) living in South Australia or Victoria; and (3) being in receipt of clinical services (which were not limited to the two gender services outlined in the introduction to this paper, and could include past or present receipt of services from any healthcare professional in relation to gender). Participants were recruited via a flyer shared with the membership of a group run by parents of transgender and gender diverse children. The research team did not have access to a membership list, and instead provided contact details on the flyer and potential participants who received it made the choice to email the research team. Participants were provided with a \$25 voucher in appreciation of their time. It should be noted that whilst the group for parents through which participants were recruited was open to all parents (including those who may be struggling to affirm their children), given that the study reported in this paper focused solely on parents whose children were in receipt of medical care, it is likely that those who participated skewed towards those largely affirming of their children (i.e., given that they had taken their children to a gender clinic and authorized medical treatment).

Data collection

Interviews were undertaken by the second author, either in person (8 interviews), or via Skype (2 interviews), depending on the preference of participants. The interview schedule was developed based on the original Canadian project, though given the Australian iteration was a pilot project, the interview schedule was reduced in length. The Australian interview questions asked both young people and their parents about (1) family relationships; (2) wellbeing; (3) coping and resilience; (4) clinic experiences; and (5) experiences of medical treatment. Interviews were conducted in May–July 2019 and averaged 77 minutes.

Interviews for the Australian iteration were dyadic, as opposed to parents and children being interviewed separately (which was the case in the

original Canadian study). Given ethics requirements in the Australian context, dyadic interviews, especially for people under 18, were considered the most appropriate way to ensure participation for young people. It is important to acknowledge, however, that whilst dyadic interviews meant that young people had a supportive adult present during the interview (which may have helped allay some fears about being interviewed by a stranger, and also helped with remembering events), having a parent present may also have meant that some young people felt that certain topics could not be broached. From our reading of the interview transcripts, however, and as the results presented below would suggest, young people appeared to speak relatively freely about a variety of topics (including their families), in front of their parents, and occasionally disagreed with the perspective of their parents.

Analytic approach

For the purpose of the present study, the analysis focused solely on items one and five in the interview schedule outlined above. Other aspects of the interview schedule will be explored in a separate paper. In terms of items one and five, the questions asked were “What is it like being in your family?” (with prompts about gender and acceptance), “Can you tell me what it is like being on medication?” (with prompts about hopes, fears, and family support), and “Has taking this medication changed how you feel about yourself?” (with prompts about feelings about bodies and gender). All interviews were transcribed by a professional service and pseudonyms were allocated following transcription.

Responses from both young people and parents to these questions and prompts were extracted for analysis. The analysis followed the approach outlined by Braun and Clarke (2006). The first author identified all of the responses to the above questions, extracted them into a document, and read the responses three times. During this process of reading the first author noted common topics (or what Braun and Clarke refer to as ‘codes’) across the extracted data. Having developed codes from the data, the first author then shared these with the second author, who

confirmed that the codes developed encompassed the most salient features of the extracted data. The first author then collated the codes, and read through the extracts pertaining to each group of codes. Through this process the first author developed themes from each of the codes. Whilst codes encompass broad salient topics repeated across the data set, themes by comparison organize codes into logical and coherent sets of information.

The first author then identified representative extracts for each of the themes, and collated these. As such, the extracts included in the results below are indicative but not exhausted of the extracts included in each theme. Having identified representative extracts for each theme, the first author then compiled the thematic groupings and developed the results reported below, which focus on latent as well as semantic meaning. The latter pertains to how each extract relates to the overall theme or sub-theme and to the broader literature, whilst latent meaning focuses more closely on the details within each extract and the individual meaning that may be accorded to them. Importantly, and as Braun and Clarke (2006) emphasize, the results presented below are informed by a constructionist theoretical lens, meaning that it is acknowledged that the findings presented are but one possible interpretation of the data set. Whilst the authors agree on the interpretation offered, there may be other possible readings available: the development of themes involves the active interpretation of the researcher.

Results

Participants

In total, ten parent-child dyads were interviewed, with one interview involving two parents (mother and step-father), making for an overall sample of 21 participants. Five of the parent-child dyads lived in South Australia, and five lived in Victoria. The average age of parent participants was 47.3 years. The average age of child participants was 14.3 years. Of the parent participants, nine reported their gender as female, one as male, and one as non-binary. Of the child

participants, five reported their gender as male, four as female, and one as non-binary. Of the parent participants, eight reported that they were married or partnered, and three reported that they were divorced or separated.

The importance of a strong supportive parent-child relationship

This first theme focuses on how both parents and children accounted for parent-child relationships in the context of gender transition and, in some instances, in the context of clinical care and other institutional contexts. This first theme is comprised of three sub-themes: (1) 'children value continuity of parental treatment'; (2) 'children know who they are'; and (3) 'families are important advocates for children'.

Children value continuity of parental treatment

When interviewed, young people often mentioned that a much valued aspect of their relationships with their parents throughout the process of gender transition was that their parents continued to treat them as the same person. For example, Amelie mentioned this when discussing how her family members show they are supportive:

Amelie: I feel like they just show that they don't treat me differently. Like even if they are supportive, I don't want them to treat me differently just because I'm a bit different, you know. They treat me like a normal human being (12 years old).

Similar to Amelie, Jasmine also emphasized the idea that being supportive means not acting differently:

Interviewer: How do [family members] show you that they're supportive of you?

Jasmine: Well, I don't think it's too difficult or too much of a challenge. I guess they just changed the pronouns, which was nice, and they haven't acted any differently (13 years old).

Jasmine makes an important point: that changing pronouns, for example, shouldn't be that difficult or challenging. Certainly, as noted in regards to the broader literature, it is often presumed that a child transitioning gender is inherently difficult or challenging (see Riggs &

Bartholomaeus, 2018, for a summary), however by contrast many (though not all) of the parents in the study reported in the present paper noted that support was automatic and not inherently difficult or challenging.

Parent participants also explained how important it is to accept a child for who they are. Marc, for example, explained:

Marc: Mariah's always been Mariah. And looking back, it's more about accepting someone and learning to accept who they are, even if that means their name becomes another name or their genders are different, that's fine, but that person hasn't changed. So you've just got to accept who they are at that point in time (parent).

The comments made by this participant speak to the broader literature on parents of transgender children, a literature that has often emphasized the idea that a transgender child is experienced as a loss (Riggs & Bartholomaeus, 2018). By contrast, Marc appears to emphasize a narrative of continuity, united by the fact that whilst a person's name or gender might change, the person does not.

Children know who they are. Echoing the affirming literature on transgender young people, this second sub-theme emphasizes the idea that being affirming means accepting that young people know their gender. A number of parents and young people emphasized the importance of believing children, such as in the following extracts:

Denise: When Amelie was younger, we were shopping for a present. My sister was visiting and Amelie went up and down the boy's aisle and came out to wherever we were and then came up to me, and said "actually, is it okay if I go into the girl's section?" and I said "of course", and she then chose Barbie dolls and my sister just went with the flow. It was quite fine. There was no issues about buying her Barbie dolls at the time. So yeah, just going with the flow. Just where the child leads, you're supposed to follow (parent).

Nate: Believe your kids. If they say something that they think is true, gender or sexuality wise, then believe them. If they come back to you and say, "Hey, that's not actually who I am, I'm something else," or, "I am still who I am, or who I was," then believe them. Don't be like, "Then why did you make us go

through all of that?" Just support them no matter what (16 years old).

Nate gives specific meaning to what we might see as an affirming approach, by emphasizing the idea that central to such an approach must be believing the child, including when the child might voice changes in their understanding of themselves. In a way this echoes the comment from Marc in the previous sub-theme, in that emphasizing that the person hasn't changed allows for a fixed point in the parent-child relationship, whilst also allowing for change and fluidity in terms of understandings of gender. In the following extract Liz emphasizes that the choices that parents make with regards to being affirming have implications in terms of the needs of the child:

Liz: I recommend involving professional help as soon as possible because a lot of parents ... I think it's quite a unique set of children, unlike say gay children who really just need the support of their parents, just some acceptance, and unlike a child with a medical condition, where the parents are told by the system what to do; right, if your child has this, you need to do this. For transgender children it's different in that the parents basically choose whether they support or not. The child then does or does not receive the care that they need (parent).

Liz here makes an interesting point of differentiation between gay children or children with a medical condition, and transgender children. It would appear, for Liz, that there is no 'choice' for parents when it comes to responding to the former groups of children, whereas for parents of transgender children there is a choice to be made: to be supportive and access medical care, or not. As Liz notes, and as we noted in the introduction to this paper, the choice that parents make has clear implications for whether or not transgender children will receive clinical care.

Families are important advocates for children

The third sub-theme in many ways builds on the second, by emphasizing that in accepting that children know who they are, parents are in the best position to be strong advocates for their children. In the first extract below, Ashleigh notes

that her parents have been important advocates to hospitals and schools:

Interviewer: So thinking of all the important people in your life, who are the most important supports for you in terms of your gender?

Ashleigh: Mum and Dad because they've really fought for me for getting the treatment in the hospital and at school. Sometimes we have had to head off issues at school. My parents just really helped me to head off, so that was really good (15 years old).

As is noted in the following extract, for some participants what is at stake in terms of parental support and advocacy is life itself:

Interviewer: So, I guess, how are they important supports for you?

Nate: Because if they didn't support me, I most likely wouldn't be here, but that goes with any child. If their parents aren't supportive of their gender or sexuality, there's a possibility that they wouldn't be here. But it's not just like the mum, dad, the parents, it's also extended family (16 years old).

Robyn: It's everybody you deal with from the dentist to the baker to being misgendered in the supermarket, so that kind of support by having that one consistent person to reinforce that to everybody around, is one of the biggest things (parent).

Both Robyn and Nate emphasize that parental, and extended family, support are important potential mitigators of broader life stressors faced by transgender young people, echoing recent research suggesting the importance of affirming family environments (Olson, Durwood, DeMeules, & McLaughlin, 2016). In the final extract below, Miles too emphasizes the importance of family support, including siblings:

Interviewer: Thinking of all the important people in your life, who are the most important supports for you in terms of your gender?

Miles: My sister, 100 percent, and my significant other, my boyfriend. So my boyfriend introduced me to non-binary and stuff. And then my ex-boyfriend taught me that gender can be fluid. And then my sister has just been really close to me and she's helped me out a lot, and she's defended me a lot. She's been really good (13 years old).

Whilst there has to date been minimal research on siblings of transgender young people, clinical

material suggests that siblings can be an important resource (Riggs, 2019). For Miles, his sister was a core support, one that helped him in terms of stressors resulting from discrimination, as he noted elsewhere in the interview.

Negotiating hormone blockers and their meaning

Of the young people who participated in the project, six were currently in receipt of hormone blockers (four of these were younger children, and two were older and were concurrently in receipt of hormone therapy). These had been accessed through one of the two gender clinics outlined in the introduction to this paper, following one (in Victoria) or two (in South Australia) independent assessments by a pediatric psychiatrist, and through consultation with a pediatric endocrinologist. In this second theme, which focuses on the receipt of, and meaning attributed to, hormone blockers, three sub-themes were developed: 1) 'parents as barriers or facilitators'; 2) 'blockers and the passage of time'; and 3) 'the relationship of blockers to sense of self'.

Parents as barriers or facilitators

For a small number of participants, there was a lack of parental consensus about accessing hormone blockers due to the parents separating or divorcing (with one of the parents refusing to consent to treatment), meaning that Court or other legal intervention was required, as was the case in the following extract:

Tara: So, for example, Paul sees his peers now going through puberty and Paul was a test case because his father wouldn't agree to puberty blockers and we had to seek counsel with lawyers, and we were going to have to take the hospital to court. Eventually Paul was able to show that he was competent enough to make that decision himself and he's ended up paving the way for other children. But that's just blockers, and Paul would really like to go through puberty with his peers and accessing testosterone is our next hurdle (parent).

Here Tara is clear about the implications of a lack of consent by Paul's father. For Paul this had been particularly distressing as whilst his medical team assessed that hormone blockers were necessary, he was left waiting beyond the

ideal time to commence blockers, due to the lack of second parental consent. As Tara notes, she was able to resolve this through legal intervention, and such intervention has paved the way for other children, but this does not mitigate the distress that Paul experienced waiting for approval.

By contrast, for Amanda it was of note that her husband, Ashleigh's father, was entirely supportive, which meant she was free to organize treatment that was in line with Ashleigh's needs:

Amanda: Ashleigh's dad's been totally on board. So because I haven't been working outside the house, I've been able to sort all this stuff out. So I've sort of organized everything, because [husband]'s at work, but that's not because he's not on board, we've just split the work up that way. Yeah. So he's never questioned whether Ashleigh needed to transition or any treatment she needed (parent)

Amongst the parent-child dyads interviewed, a dissenting parent was most common in families where the parents were separated. This is not to suggest, however, that dissent does not occur within families where the parents have not separated. Certainly previous research has found that fathers in general may be more likely to struggle with being affirming of a transgender child, than may mothers (Riggs & Due, 2015).

Blockers and the passage of embodied time

A common narrative appended to discussions about hormone blockers involves the idea that they serve to 'pause' time, allowing for young people to explore their gender (Riggs, 2019). Whilst this idea of 'pausing time' has been critiqued for its developmentalist assumptions (Castañeda, 2015), many of the parents and children interviewed for the study drew upon this narrative, albeit in a range of ways, such as is evident in the following extract:

Interviewer: So Amelie, can you tell me a bit about how you feel about puberty?

Amelie: Scared. Really scared (12 years old).

Interviewer: And do you discuss it with your mum?

Amelie: Yes. That's why I wanted the puberty blockers, because I don't – I feel like I'm running out of time. It's like ticking. I feel like a little ticking

clock and then the alarm goes off actually. I've already hit puberty a bit, so, you know.

For Amelie, approaching puberty was like a 'ticking clock' with an impending alarm. The impending nature of puberty was fear-inducing for Amelie, and as other participants noted, such as in the following extract, the reduction of fear through prescribing hormone blockers was seen as saving lives:

Kristina: We were relieved. I think the biggest bonus to puberty blockers is that you have time to help your child navigate... They just save lives. There's other people that I've worked with that were on the brink of doing something really serious to themselves that were able to access puberty blockers and it just saved their lives. They were able to pause what they were going through (parent).

Here Kristina makes reference to the idea that hormone blockers produce a pause, one that prevents young people who are 'on the brink' from doing something 'really serious'. Marc too referred to hormone blockers as 'buying time':

Marc: [I]t just buys you time and there's that relief that you're getting that, but that's about all the benefits that you get out of the blockers, I think (parent).

Similar in a way to Kristina, Marc suggests that hormone blockers served to provide relief for their daughter Mariah, potentially referencing relief from what Amelie referred to as fear, and Kristina referred to as being on the brink.

The relationship of blockers to sense of self

In terms of whether or not receipt of blockers had implications for young people's sense of self, a number of participants noted that whilst blockers did not *per se* do anything to affirm their gender, they did nonetheless serve to prevent physical changes that would have been counter to their sense of their gender:

Interviewer: Did blockers help affirm that you were a girl?

Ashleigh: Not really. I just knew 100% that I was a girl, so ... no, nothing really affirmed it, I just knew. Because like that would be like if anyone, a cisgender person were to get an injection to block puberty because there was a problem with their puberty, they'd still feel the same about themselves (15 years old).

Here Ashleigh makes an important point of comparison, namely that cisgender children would still feel the same about themselves if they had an injection to block puberty (which can occur in the case of 'precocious puberty'). As Ashleigh notes, hormone blockers would make no change in a cisgender child's sense of their gender, just as they make no change in terms of a transgender child's sense of their gender. Mariah echoed this sentiment:

Interviewer: And what about in terms of the blockers?

Mariah: They didn't really help with my self-esteem. They don't change or anything. They don't affirm your gender, they just stop puberty (17 years old).

Interviewer: So would you also then say it didn't change how you felt about your gender?

Mariah: I was happy that it stopped me from going through male puberty and starting to be more masculine. So, I guess, that helped, but in terms of affirming how I feel femininely, it didn't really do that.

Again, Mariah reiterates that hormone blockers didn't affirm her gender, though they did mean she didn't have to go through a puberty that did not align with her gender, a point also made by Jasmine:

Interviewer: And what were you hoping for in taking blockers?

Jasmine: That I don't go through real puberty. I don't know. I guess it still did happen very much, but it sort of helped me feel a bit more like a girl, I guess. I don't know. The fact that I would've been going from male puberty from that point forward, I guess. (13 years old)

Liz: It was another step, wasn't it? (parent)

Jasmine: Yeah.

For Jasmine, hormone blockers were affirming in that they allowed her to feel confident in her gendered embodiment as female, specifically because no changes would happen to masculinize her body. Further, and as Liz suggests, the receipt of blockers meant that Jasmine felt 'another step' had been taken in affirming her gender. As such, whilst blockers *per se* did not affirm her gender, the receipt of them did

signal that her gender was being taken seriously, and that medical treatment was proceeding as desired.

Negotiating hormones and their meaning

Of the young people interviewed, four were currently in receipt of hormones (of whom two were concurrently in receipt of hormone blockers, and two were only in receipt of hormones). As is the case with hormone blockers, hormones are prescribed in Australia following assessment by one (in Victoria) or two (in South Australia) independent pediatric psychiatrists, and in consultation with a pediatric endocrinologist. Some young people may be in receipt of both hormone blockers and hormones, as ongoing receipt of blockers may reduce the dosage rate of hormones, though some young people may only be in receipt of hormones if they presented for treatment after puberty. Within this final theme, four sub-themes were developed: (1) 'the impact of the court system'; (2) 'the impact of service wait times'; (3) 'parent journeys to understanding'; and (4) 'the relationship of hormones to sense of self'.

The impact of the court system

Whilst, as noted in the introduction to the present paper, receipt of hormone therapy no longer requires Court approval, for some of the people interviewed they had begun the process at a time when this was still required, as was the case for Kya:

Interviewer: So going back to the clinic, would you say anything significant has changed since you started going there?

Kya: I don't know if it is completely out of the realm of what you're asking, but the law that allows people under 18 to access hormones without having to go through the family court, definitely the change was good. It would've been a lot more annoying and exhausting if that was a thing I would've had to do and I probably wouldn't have honestly done it, I would've just waited (17 years old).

Johannah: Waited until you were 18. Which would've definitely been bad for Kya's mental health to have to tread water for that long, so we're very fortunate and very grateful that the law got changed (parent).

Whilst Kya and Johannah appear clear that, should Court approval have been still required, they would have waited until Kya was 18 (when Kya would have been an adult and could have consented to her own treatment), this would not have been without psychological consequences. Other research on delays caused by the previous Australian requirement for Court approval suggests that such delays produced considerable distress for many young people and their families (Kelly, 2016). For other young people, and similar to the case of hormone blockers, delays were the product of both the Court process required at the time, in addition to one parent delaying in giving consent, which was the case for Mariah:

Interviewer: What was involved in starting hormones and what was that like for you?

Mariah: So I needed an attorney (17 years old).

Kristina: Yes. It was complicated. It's much easier now, and I love that, but for us, it wasn't. And, so we connected with [pro bono legal service] who actually offered us a lawyer and legal representation. She was a criminal barrister and so she was actually really switched on. But that process was slowed down because of her father. It was to the wire with him. It wasn't until we called and said that we were going to serve him with papers at his work, that he was like, "Okay. I'll sign the papers," and that was really nerve-racking (parent).

Kristina and Mariah were fortunate that they had a well informed barrister, who could advocate for their case. Whilst Mariah's father eventually signed the necessary documentation for the Court process to proceed, the risk that he might not was particularly 'nerve-racking', given that the outcome may have been different if there was one dissenting parent.

The impact of service wait times

This second sub-theme echoes the broader literature (e.g., Tollit, Feldman, McKie, & Telfer, 2018), in terms of its emphasis upon the implications of service wait times for young people and their parents. For Kya and her mother Johannah, the problem of extended wait times was exacerbated by the need to change plans at short notice:

Johannah: I guess we had a long waiting period until we could access the service, I think it was about nine months' wait between when we first did the referral to the first meeting. And then we got a cancellation so then we only had to wait maybe four or five months between that first introduction to the service and before we got our appointments, and once we had the appointments it moved pretty quickly from there. But it's one of those things, all hurry up and wait all the time, you think okay, we've gotten into the service, fantastic, and then you had to go back on the waiting list for the next lot of appointments (parent).

Interviewer: So, Kya, you said it was long but it was quicker than other people?

Kya: Yeah, because of the cancellation that we had we were able to get in slightly earlier and the process was jump-started, I guess (17 years old).

Johannah: And also it was a matter of when they made the phone calls saying are you available you just dropped everything and rearranged everything and made it work and jumped in the car and got down there, so it wasn't, yeah, it's not an ideal way to go about it but it was definitely better than waiting for a number of months.

Whilst Kyra was thankful that her access to services was 'jump-started', the process was still, as Johannah notes, 'not an ideal way to go about it', because of the need to change other existing plans so as to be able to attend an appointment given at short notice. Marc too notes that earlier access would have been ideal, and his wife Kristina notes again that a cancellation made earlier access possible:

Marc: I was just going to say, probably, earlier access to hormones, that would've been good (parent).

Kristina: Yes. I mean, I was persistent with calling – we were on a waitlist for six months, but it was still a really long six months. And I called up frequently to see if there was any progress almost every day. And then someone couldn't make it in and that's how we actually got in earlier. But before that, I think it was 18 months, and I was like, that's not going to work. So that's why I was really persistent in calling every day and, so I think to reduce the waiting time would benefit (parent).

Whilst Marc and Kristina note that overall their experience of accessing hormones for Mariah was positive, it was nonetheless the case

that persistence was required, and that potentially without such persistence the wait time may have been greatly extended, which as Kristina notes, would not have worked for Mariah. For Ashleigh, by contrast, there was a sense of disarray to the process of accessing hormones, including wait times:

Interviewer: Going back to the hormones, this might give you a chance to add anything you didn't say earlier, is there anything that might have been done differently to improve your experience?

Ashleigh: Maybe minus all the negative stuff, being told that it would never happen, and no false hope and just sticking to facts, because even if I had been told "no, it would maybe be another year" I would have been able to prepare myself, but yeah. And also I think just having a process and not just being seen like it's just happening higgledy-piggledy and it's just randomly being done, like how the report was only done in a few days, it was done just in time because they hadn't been told anything about it (15 years old).

Here Ashleigh is clear that what is required is clear information about wait times for accessing hormones so that young people can be prepared, rather than what seemed to Ashleigh like a 'random' process, such as a report she needed being completed just in time.

Parent journeys to understanding

As noted in the introduction to this paper, access to services for young people may largely be shaped by parental views about the need for services. For some of the young people interviewed, there was an initial process by which parents needed to come to a place of understanding, so that access to services was possible:

Interviewer: So who first brought up the hormones?

Kya: I don't know, it must've been me (17 years old).

Johannah: We had a number of conversations early on, but as I said, because I still had a lot of learning to do it was tricky, we weren't communicating as well as we could, not as well as we do now. When she would mention hormones, I certainly didn't do a lot of research on looking into how I might go about that because I didn't understand if she really wanted them or not. Yeah, we would've been benefitted earlier on if we had someone to just ask the right

questions of me and of Kya, we could've saved a lot of angst (parent).

Interviewer: So, Kya, when you talked about wanting hormones did you feel understood by your parents?

Kya: I can't remember because it was so long ago, but I assume not, I was probably in the mindset of no one understands me, oh, I'm so sad, blah blah blah, a typical teenager mindset.

Johannah was honest in her early response to Kya, acknowledging that her lack of research and guidance about questions meant that there was some delay in accessing treatment. Whilst Kya passed her feelings off as teenage angst, it appears clear that early conversations about treatment were difficult for the family, and support would have been an important facilitator of more expedient outcomes. For Nate, it was the case that his father needed questions answered:

Interviewer: So what was involved in starting hormones and what was that like for you?

Robyn: So we were very lucky in our timing that Nate was of an age to start very shortly after [Court decision] was announced. Effectively, with Nate, because he had already been in the service for two years by that point, it was a straight forward questionnaire on competency at that point which took about an hour for him to go through that. So, yes, effectively, it was just the competency paperwork, have Dad sign the papers, have Mum sign the papers, and bang, it's there. So it was a reasonably painless, though the lead up was difficult as Dad needed answers to certain questions about side effects (parent).

Interviewer: I think Nate just rolled his eyes.

Nate: Yes (16 years old).

Robyn: Dad had no idea. Dad had no idea of what it would do, how reversible it was and was scared. Dad was scared. He was scared for his future grandchildren. I think he was also scared for Nate. I think he was scared more from a personal perspective, that he was going to lose his daughter, that sort of stuff. But his fears were allayed, and he realized that this is going to happen regardless.

Robyn's comments about Nate's father echo points made earlier in this paper about parental narratives of 'loss', and the struggles that men

may face in particular in coming to a place of affirming a transgender child. Whilst eventually Nate's father allowed Robyn to take the lead, this did not mean that there were not delays that were a product of the father's fears, fears that, as Robyn notes, needed to be allayed before treatment could proceed.

The relationship of hormones to sense of self

This final sub-theme echoes the final sub-theme of the previous theme in its focus on the degree to which the receipt of hormones was related to a changed sense of self, particularly with regards to gender. Different to the sub-theme on hormone blockers, young people were clearer about the positive effects of the receipt of hormones. However, hormones were not simply a magical pill that rendered any existing concerns or distress moot:

Interviewer: Okay. So I know you don't want to talk about physical changes, but maybe wellbeing and emotions, is that something?

Kya: It seems better, I'm more happy, I'm feeling better within myself (17 years old).

Interviewer: Johannah, did you want to say anything in terms of wellbeing as well, like have you noticed any changes in wellbeing?

Johannah: Yeah, for sure. I see Kya to be more confident, parts of her personality that I saw when she was younger have come back like the extravert, the performance part of her personality. I just feel that with the weight of this off her shoulders she can just be Kya, so, yeah, like I said it's not really a thing anymore, it's, yeah, she can just live her life (parent).

Kya was reticent to talk about physical changes, and the second author did not push the topic, however both Kya and Johannah spoke about positive changes in terms of wellbeing. As Johannah noted, Kya seemed more able to be herself, to an extent free of stressors associated with waiting to be in receipt of hormones. Mariah too noted that receipt of hormones produced positive changes for her sense of self:

Interviewer: That was the next question I was going to ask, if it changed how you felt about your body.

Mariah: On hormones, as my body became more feminine, my self-image started becoming a lot more

positive and I started feeling a lot — loving my body more. But I still have those thoughts in my mind like, you're fat, you're still very masculine or whatever, those type of thoughts (17 years old).

Mariah here makes an important point: that with the changes brought about by hormones, she was more able to love herself, but this did not entirely ameliorate negative feelings that persisted, negative feelings that may to a certain degree be true for many adolescents.

Discussion

This paper has presented the first findings from an Australian pilot study focused on transgender young people and their parents, specifically in terms of their views on clinical care. Aspects of the findings support previous research, specifically with regard to the negative impact of service wait times upon the wellbeing of transgender young people and their families (e.g., Gridley et al., 2016; Tollit et al., 2018), and the negative impact of Court requirements (Kelly, 2016). The findings also usefully build on limited previous research that has explored the need for parents to be led by children in terms of their gender transition-related needs (Aramburu Alegría, 2018; Pyne, 2016), and research that has explored the positive effects of medical treatment as providing relief and a 'step forward' in terms of transition (Sansfaçon et al., 2019), and that such treatment allows children to be 'back to being themselves' (Aramburu Alegría). As we shall now explore in terms of implications for the practice, the findings reported in this paper also represent novel insights that extend the existing literature in important ways.

Implications for practice

As noted above, the findings reported in this paper extend the previous literature in useful ways in terms of clinical care. Sub-themes related to parental journeys to acceptance, and parents as facilitators of, or barriers to, treatment, highlight that what parents need are affirming and informative sources of support that help them to come to a place of understanding, a place where accessing treatment is seen as viable and necessary.

This may involve supporting parents to work through potential feelings of 'loss' (Malpas, 2011), but it should not begin or end with this type of narrative (Riggs & Bartholomaeus, 2018). Instead, and as the findings presented in this paper suggest, a focus on continuity in terms of the relationship with the child may be an important avenue for exploring parental concerns about medical transition.

Further in terms of clinical implications, the findings presented in this paper with regard to views about the passage of time herald important insights for clinical care. How young people and their parents understand the passage of time, in terms of both service wait lists and the role of hormone blockers may serve as useful points of discussion. This may involve ensuring that those waiting for appointments understand that services may triage appointments, and that a delay does not mean that the service is unsupportive or unwilling, but rather that people are seen in order of need. Clear information in this regard may help, at least to some extent, to alleviate concerns about wait times. Views about the changes brought on (or not) by hormone blockers and hormones, and indeed views about the role of the former as creating a 'pause', may be usefully harnessed to allow for careful explorations of the likely outcomes of medical treatment: what can be expected, what is unlikely to occur, and how both of these relate to sense of self. Being prepared for what might come with medical treatment requires an understanding of one's self, the expectations one has, and the capacity to be aware of one's own fears and concerns.

Limitations

These important and useful findings and implications for practice must be put into context of the fact that the study reported in the present paper was a pilot, with a relatively small sample size. It was also limited to two Australian states, and included parent-child dyads where the child was relatively supported in their desire to access medical treatment. Future research should focus on experiences in other Australian states, with families where support may be less than forthcoming, with younger children looking ahead to potential

medical treatment in the future, and may usefully involve individual interviews with young people on their own. Whilst it is suggested that in the interviews young people on the whole appeared able to share their feelings openly, including those in relation to their parents, other avenues of conversation may have been more possible in one-on-one interviews.

Conclusion

In conclusion, a key point arising from the findings presented in this paper is that, by and large, transgender young people know who they are, they know their gender, and they know the services they need. Certainly, there are aspects of their gender-related journeys that may be unknown, but that is true for any journey that involves focusing on the self. Parents of transgender young people, and the service providers who work with them, have an important role to play in listening to young people's accounts of their needs, supporting them by offering affirming responses, and facilitating, in as expedient fashion as possible, their access to services. So doing, the findings reported in this paper would suggest, holds the greatest potential to mitigate or minimize distress, and instead to allow transgender young people to live their lives fully.

Disclosure statement

The authors declare they have no conflict of interest



Informed consent

Informed consent was obtained from all individual parties included in the study.

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